STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS
2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833-2945
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DUE DATE: OCTOBER 14, 2011

ANNUAL REPORT

July 1, 2010 – June 30, 2011

☐ **Vocational Nurse Program** ☐ **Psychiatric Technician Program**

SCHOOL/CAMPUS NAME: _____

Check Appropriate Box(es): ☐ Full-Time ☐ Part-Time

Official Mailing Address: _____

Program Director: _____

Director's Office Telephone: (___) _____ Fax: (___) _____ Email Address: _____

Administrator: _____

Administrator's Office Telephone: (___) _____ Fax: (___) _____ Email Address: _____

PROGRAM ACCREDITATION

BVNPT Accreditation:

Initial Approval Date: _____ Last Accreditation Date: _____ Date of Expiration: _____

Other Accreditations: ☐ Yes (*Please specify):*_____ ☐ No

CLASS DATA

1. Board **approved # of students/class**: Full-Time:____ Date:_____ Part-Time:____ Date: _____
2. **Approved frequency of admissions**: Full-Time:____ Date:_____ Part-Time:____ Date: _____
3. Was an increase in class size or frequency requested during this reporting period? ☐ Yes ☐ No
   If yes, please provide the date and amount of increase: _____
4. For the period **July 1, 2010 through June 30, 2011**, please provide the following information *per class*.
   a. # Applications Received: Full-Time Part-Time
      1) Class #1: _____ _____
      2) Class #2: _____ _____
   b . # Students **Admitted**: Full-Time Part-Time
      Please list the **months** and **#** of students
      1) Class #1: _____ _____ _____ _____
      2) Class #2: _____ _____ _____ _____
   c. # Students **Graduated**: Full-Time Part-Time
      Please list the **months** and **#** of students
      1) Class #1: _____ _____ _____ _____
      2) Class #2: _____ _____ _____ _____
5. Does the program conduct classes year round? ☐ Full-Time ☐ Part-Time

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE INFORMATION ON A SEPARATE PAGE.

CURRICULUM INFORMATION

Upon which of the following nursing theories is the program's conceptual framework based.

☐ Maslow ☐ Orem ☐ Roy ☐ Other (*Please specify*):_____

Please provide the number of hours/units for <u>every content area</u> below. Integrated content should be reflected by enclosing the hours in parentheses. <u>Total program hours should include the sum of all theory and clinical hours</u>. Please use an asterisk (*) to indicate prerequisite hours/units.

Vocational Nursing Programs Only:	Hours/Units	
	Theory	Clinical
A. Anatomy & Physiology		
B. Nutrition		
C. Psychology		
D. Normal Growth & Development		
E. Nursing Fundamentals		
F. Nursing Process		
G. Communication		
H. Patient Education		
I. Pharmacology		
J. Medical-Surgical Nursing		
K. Communicable Diseases		
L. Gerontological Nursing		
M. Rehabilitation Nursing		
N. Maternity Nursing		
O. Pediatric Nursing		
P. Leadership		
Q. Supervision		
R. Ethics & Unethical Conduct		
S. Critical Thinking		
T. Culturally Congruent Care		
U. End-of Life Care		
TOTAL HOURS/UNITS		
TOTAL PROGRAM HOURS/UNITS:		

Psychiatric Technician Programs Only:	Hours/Units	
	Theory	Clinical
A. Anatomy & Physiology		
B. Nutrition		
C. Psychology		
D. Normal Growth & Development		
E. Nursing Process		
F. Communication		
G. Nursing Science:		
1. Nursing Fundamentals		
2. Med/Surg Nursing		
3. Communicable Diseases		
4. Gerontological Nursing		
H. Patient Education		
I. Pharmacology		
J. Classifications of Developmental Disabilities		
K. Classifications of Mental Disorders		
L. Leadership		
M. Supervision		
N. Ethics & Unethical Conduct		
O. Critical Thinking		
P. Culturally Congruent Care		
Q. End-of Life Care		
TOTAL HOURS/UNITS		
TOTAL PROGRAM HOURS/UNITS:		

CAREER MOBILITY

Relative to career mobility, please check **all types** of nursing and related programs offered.

☐ **CNA to LVN** ☐ **LVN to PT** ☐ **PT to LVN** ☐ **LVN to ADN** ☐ **Other** (*Please specify*):_____

TIME BASE

Please indicate <u>type</u> (FT=full–time, PT=part–time, or WE=weekend) and <u>length</u> of classes offered.

Type: _____ How is the program divided? ☐ Quarters ☐ Semesters ☐ Modules ☐ Other *(Please specify):*_____

Number of weeks per term/module: _____ Total length of program:_____weeks/quarters/semesters

Does the program include a **<u>Preceptorship</u>**? ☐ Yes ☐ No

Number of Preceptorship hours:_____ Date of Board Approval: _____

Type: _____ How is the program divided? ☐ Quarters ☐ Semesters ☐ Modules ☐ Other *(Please specify):*_____

Number of weeks per term/module: _____ Total length of program:_____weeks/quarters/semesters

Does the program include a **<u>Preceptorship</u>**? ☐ Yes ☐ No

Number of Preceptorship hours:_____ Date of Board Approval: _____

Type: _____ How is the program divided? ☐ Quarters ☐ Semesters ☐ Modules ☐ Other *(Please specify):*_____

Number of weeks per term/module: _____ Total length of program:_____weeks/quarters/semesters

Does the program include a **<u>Preceptorship</u>**? ☐ Yes ☐ No

Number of Preceptorship hours:_____ Date of Board Approval: _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE INFORMATION ON A SEPARATE PAGE.

ADMISSION, SCREENING & SELECTION PROCESS

1. Please check all **<u>admission criteria</u>** applicable to your program.

☐ 12th Grade Completion or Equivalent. Is documented proof required prior to admission? ☐ Yes ☐ No

☐ Completion of specific admissions test? ☐ Yes (*Please specify):* _____ ☐ No

☐ Certification (*check all applicable):* ☐ HHA ☐ CNA ☐ CPR ☐ Other *(Please specify):* _____

☐ Course prerequisites in addition to those listed on Page 2. (*Please specify):* _____

_____

2. Please check all **<u>screening and selection criteria</u>** applicable to your program.

☐ Random Selection

☐ Grade Point Average (*Please specify):* _____

☐ Screening Instrument Used:

☐ Assessment Technology Institute (ATI) ☐ California Proficiency Achievement Test (CPAT)

☐ Health Education Systems, Inc. (HESI) ☐ Kaplan

☐ National League for Nursing (NLN) Pre Admission ☐ Test of Adult Basic Education (TABE)

☐ Wonderlic ☐ Other (*Please specify):* _____

Please specify **<u>minimal score required</u>** for the screening instrument used*:* _____

☐ Other criteria *(Please specify):* _____

ASSESSMENT TESTS

1. Does the program require completion of assessment tests? ☐ Yes ☐ No

2. Please indicate the assessment instrument utilized. (*Check all appropriate boxes)*

☐ Assessment Technology Institute (ATI) ☐ Admission ☐ Specialty Exam ☐ Exit

☐ Health Education Systems, Inc., (HESI) ☐ Admission ☐ Specialty Exam ☐ Exit

☐ National League for Nursing (NLN) ☐ Admission ☐ Specialty Exam ☐ Exit

☐ Other (*Please specify):*_____ ☐ Admission ☐ Specialty Exam ☐ Exit

3. Is successful completion of an assessment test required for **program graduation**? ☐ Yes ☐ No

If yes, are students notified of the requirement upon admission? ☐ Yes ☐ No

PLEASE ATTACH A COPY OF THE NOTIFICATION.

4. Other uses for assessment tests.

Do you utilize assessment tests to evaluate the **effectiveness of the program curriculum?** ☐ Yes ☐ No

If yes, how are results measured? _____

If no, how is the effectiveness of the curriculum measured? _____

PLEASE ATTACH A COPY OF THE INSTRUMENT USED.

Do you utilize assessment tests to evaluate **student achievement**? ☐ Yes ☐ No

If yes, how are results measured? _____

If no, what instrument is used to measure student achievement? _____

PLEASE ATTACH A COPY OF THE INSTRUMENT USED.

EXAMINATION REVIEW COURSES

1. Does the program offer review courses? ☐ Yes ☐ No

If yes, check all that apply: ☐ NCLEX/PN ☐ CAPTLE ☐ Other *(Please specify):*_____

2. Is enrollment in review courses restricted to enrolled students? ☐ Yes ☐ No

3. Is successful completion of a review course required for program graduation? ☐ Yes ☐ No

If yes, are students notified of the requirement upon admission? ☐ Yes ☐ No

PLEASE ATTACH A COPY OF THE NOTIFICATION.

REFRESHER COURSES

1. Does the program offer **refresher courses**? ☐ Yes ☐ No If yes, for which program(s)? ☐ VN ☐ PT

2. Please indicate your **enrollment requirements**.

Prior failure of NCLEX/PN or CAPTLE. ☐ Yes ☐ No

Current inactive licensure. ☐ Yes ☐ No

Other *(Please specify):* _____ ☐ Yes ☐ No

3. Have you requested placement of your refresher course on the Board's website? ☐ Yes ☐ No

FACULTY MEETINGS

Please indicate the following information regarding your program's **faculty meetings**.

1. Meeting Frequency: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other *(Please specify):*_____

2. Meeting Content (*Please specify frequency per content area)*:

- Curriculum evaluation/revision: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other *(Please specify):*_____
- Student achievement: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other *(Please specify):*_____
- Effectiveness of remediation: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other *(Please specify):*_____
- Criteria for academic probation: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other *(Please specify):*_____
- Program evaluation: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other *(Please specify):*_____
- Clinical facility evaluation: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other *(Please specify):*_____
- Other *(Please specify):*_____

CULTURAL DIVERSITY OF STUDENT POPULATION ***(OPTIONAL)***

During the crisis in health care and nursing shortage, the Board is frequently asked by the Legislature and the Governor's office to provide data regarding the cultural diversity of California's workforce. For that reason, the following data is requested. ***Please note, that only aggregate data will be reported; individual programs will not be identified.***

Please complete the table below by listing the number of students in each category for all enrolled classes starting or graduating during the reporting period **July 1, 2010 through June 30, 2011**.

Example

06/06/09	**12/15/10** (Class graduated in this reporting period)	10	10	10	10	10	10
09/05/09 (Class started in this reporting period)	12/15/11	12	5	15	8	1	3

Submit additional page if necessary.

I HEREBY CERTIFY under penalty of perjury under the laws of the State of California that the information contained in this Annual Report is true and correct.

Program Director's Signature: _____ Date: _____

DUE DATE: OCTOBER 14, 2011

Attachment A: Faculty Information

Attachment A is to reflect all Board-approved faculty for your program. Please list but mark through the names of faculty who no longer teach for your program and vacated the position within the period of this report. The legend for Attachment A is as follows:

** **Degree:** **A** = Associate Degree; **B** = Bachelors Degree; **M** = Masters Degree; **D** = Doctoral Degree

*** **Position Codes**: **D** = Director; **AD** = Asst. Director; **I** = Instructor or Substitute (nursing); **AF** = Additional Faculty; **TA** = Teacher Assistant

**** **Work Schedule**: **FT** = Full-Time **PT** = Part-Time **S** = Substitute

Attachment B: Clinical Facility Information

Attachment B is to reflect all Board-approved clinical facilities in which you have indicated that your program's students received clinical experience during the last 24 months. Facilities not utilized within that time frame will be deleted from your program's list of approved clinical facilities. Future use will necessitate the completion of a new Clinical Facility Approval Application. Please list but mark through any names of facilities you stopped using during this reporting period. The legend for Attachment B is as follows:

* **Non Use:** Please place a check in this column if the designated facility was not utilized for clinical experience during the last 24 months.

** **Facility Codes:** **AC** = Acute Care; **AS** = Ambulatory Surgery; **COM** = Community Care; **COR** = Corrections; **DC** = Day Care; **GH** = Group Homes; **HH** = Home Health; **IC** = Intermediate Care; **LTC** = Long Term Care; **OP** = Outpatient; **PO** = Physician's Office; **P** = Preschool; **R** = Rehabilitation; **SNF** = Skilled Nursing Facility; **STP** = Specialty Treatment Programs; **SS** = Special Schools; **TC** = Transitional Care; **O** = Other *(Please specify).*

PT Programs Only - **CDU** = Chemical Dependency Unit; **MHC** = Mental Health Clinics; **PH** = Psychiatric Hospitals; **VE** = Vocational Education & Training Centers;

*** **Clinical Use Codes:** **Fun** = Fundamentals/Nursing Science; **M/S** = Medical/Surgical; **C Dis** = Communicable Diseases; **Geron** = Gerontological Nursing; **Rehab** = Rehabilitation Nursing; **Matern** = Maternity Nursing; **Ped** = Pediatric Nursing; **L/S** = Leadership & Supervision.

PT Programs Only - **MD** = Mental Disorders